UNUMPROVIDENT

INCOME PROTECTION CLAIM

Mail to: The Benefits Center, P.O. Box 12030, Chattanooga, TN 37401-3030
Claim Questions: 800.633.7479 **Fax To:** 423.755.3009

A. ATTENDING PHYSICIAN'S STATEMENT (PLEASE PRINT)

Name of Patient	Home Telephone Number	Date of Birth	Social Security Number
ZOREA STARR	212 787 9862	07.04.64	518-98-6170

Employer Name	Employer Telephone Number
Time Warner Cable	203-328 0600

Instructions: If this claim is related to normal pregnancy, complete the Normal Pregnancy section. For all other claims, including complicated pregnancy, complete the All Other Conditions section. **In all situations, you must complete the signature block at the bottom of this form.**

Normal Pregnancy

1. Expected Delivery Date: | If Delivered, Actual Delivery Date: | Type of Delivery ☐ Vaginal ☐ C-Section
2. Date First Unable to Work | Date Hospitalized
3. Has patient been released to work in her own occupation? ☐ Yes ☐ No In any occupation? ☐ Yes ☐ No
   If not, when should the patient be able to return to work? Full Time | Part Time

All Other Conditions

1. **Diagnosis** - Please include the primary diagnosis and list any secondary conditions.

Diagnosis (including any complications) include ICD9 and/or DSM IV Multi Evaluation Nomenclature and Code Number

309.0 ADJUSTMENT DISORDER C DEPRESSED MOOD (DSM IV), (ICD-9).
564.1 IRRITABLE BOWEL (ICD-9-CM)

2. Date First Unable to Work 08.30.04 | Date Hospitalized
3. Has patient been released to work in his/her own occupation? ☐ Yes ☒ No In any occupation? ☐ Yes ☐ No
   If not, when should the patient be able to return to work? Full Time UNDETERMINED Part Time
4. Is this disability related to the patient's employment? ☐ Yes ☐ No ☒ Unknown
5. If complicated pregnancy | Expected Delivery Date: | If Delivered, Actual Delivery Date: | Type of Delivery ☐ Vaginal ☐ C-Section
6. Date of first visit for this illness or injury 08.30.04
7. Nature of treatment (including surgery and medications prescribed)

	Name of Surgical Procedure	Date of Surgery
PSYCHOTHERAPY A. MEDICATION		

8. If the patient has demonstrated a loss of function, please describe restrictions and limitations in the space provided below.

RESTRICTIONS (What the patient should not do)
PT. SHOULD NOT BE EXPOSED TO COMPLEX A. DEMANDING WORK, OR BE ENGAGED IN REGULAR WORK AND PERFORMANCE CORD AND RESPONSIBLE A. RESPONSIBLE INTERACTION C CLIENTS A. PEERS.

LIMITATIONS (What the patient cannot do)
PT. CANNOT MAINTAIN FOCUSED CONCENTRATION, OR CLARITY OF MIND, SHE LACKS CURRENTLY PHYSICAL A. MENTAL STRENGTH TO FUNCTION AT HER REGULAR LEVEL OF PROFESS. SKILLS, SHE EXPERIENCES VERTIGO WHEN SITTING UP.

Date restrictions and limitations began AFTER SEVERAL MONTHS OF DISTRESS OF INCREASING SEVERITY PT. BECAME TOTALLY DISABLED ON 8.28.04

9. Referring physician or other treating physicians (names, addresses, telephone numbers):

Please include copies of all applicable office notes and test results.

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

Print or Type Name	Degree	Medical Specialty
Joerg Bose, M.D.		PSYCHIATRY
Street Address 20 West 74th Street		Telephone Number 212 787 9041
City New York	**State** N.Y.	**ZIP Code** 10023	Fax 212 362 6967
Signature of Physician Joerg Bose		Date 9.17.04
SSN or Employer's ID Number 189-42-8496	Are you, the physician, related to this patient? ☐ Yes ☒ No If yes, what is the relationship?	

1194-02 (8/04)